Health Sciences Program Authorization and Consent

I, _____, the parent or guardian of_____, a student who is interested in enrolling in the _____Health Sciences Program do authorize and consent for my child/ward to participate in classroom and clinical activities. I understand that for complete participation in this program, verification that the student's name is not on the Employee Disqualification List and/or the Registry for the Federal Marker, and a State Criminal Background Check will need to be completed. I give permission to obtain a State Criminal Background Check and have attached a copy of my child/ward's Social Security Card for verification of the Employee Disqualification List and the Registry for the Federal Marker. I do understand that if my child/ward's name is on the Employee Disqualification List or my child/ward has been convicted of a criminal offense applicable to Section 660.317, he/she will be unable to enroll in the_____ Health Sciences Program. I am also aware that the information obtained will be provided to each local healthcare facility where my child/ward will perform patient care.

Parent Signature: _____

Student Signature: _____

Date: _____